

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR			
James Edward Beverly						February 8 1969			1:20 AM			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years lost birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Male		White		4-25-19			49 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH					
Maryland		U.S.A.					Calvert County Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
Prince Frederick			Calvert County Hosp.			Bartender						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
Maryland			Calvert		Owings				-----			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME									
First Middle Last			First Middle Last									
William Beverly			Elizabeth Bafford									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address						
No			214-12-3576			Mrs. Thomas Cochran, Owings, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												
PART 1. DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) <i>Cirrhosis of liver</i>												
571.9 DUE TO, OR AS A CONSEQUENCE OF												
(b) <i>Adenocarc.</i>												
DUE TO, OR AS A CONSEQUENCE OF												
(c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
MEDICAL CERTIFICATION												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan.</u> , 19 <u>67</u> , to <u>Feb. 8</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>Feb. 7</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE			22c. DATE SIGNED			22d. PHYSICIAN'S NAME (Type)						
<i>Issam El Dama louji</i>			2-8-69			Prince Frederick, Maryland						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial			Feb. 11, 1969			Waters Memorial Chr. Cem Mutual			Calvert Md.			
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE						
<i>Hutchins Funeral Home Owings, Md.</i>			DATE FEB 13 1969			<i>Charles Young</i>						

00188

00188

James Edward Beverly John W. 10-3-1904

19-10-1904
Beverly James
Beverly James

James Edward Beverly
Beverly James
Beverly James

Beverly James Beverly James

James Edward Beverly John W. 10-3-1904

James Edward Beverly
John W. 10-3-1904

00188

James Edward Beverly John W. 10-3-1904

James Edward Beverly John W. 10-3-1904

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02197										02193														
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										CERTIFICATE OF DEATH														
1. DECEASED-NAME (Type or print)					First Middle Last					2a. DATE OF DEATH					2b. HOUR									
Arthur Yates Chapman										Month Day Year					10:30 PM									
3. SEX					4. RACE					5. DATE OF BIRTH					6. AGE (In years lost birthday)									
male					Negro					3-4-10					58 YRS.									
7a. BIRTHPLACE (State or foreign country)					7b. CITIZEN OF WHAT COUNTRY?					8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH									
Maryland					U.S.A.										Calvert Md.									
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)					12b. KIND OF BUSINESS OR INDUSTRY									
Prince Frederick					Calvert County Hosp.					Janitor					Ed. of Ed.									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE					13b. COUNTY					13c. CITY OR TOWN					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
Maryland					Charles					Bryantown														
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME																			
First Middle Last					First Middle Last																			
John Chapman					Erma Yates																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)					16b. SOCIAL SECURITY NO.					17. INFORMANT					Address									
no					219-05-1611					Mildred Chapman					Bryantown, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF <u>7824</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																								
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)														
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)					21f. LOCATION Street or R.F.D. No. City or Town County State														
22a. I certify that (I) (this hospital) attended the deceased from <u>Oct. 23, 1968</u> to <u>Feb. 2, 1969</u> , that (I) (we) last saw the deceased alive on <u>Feb. 2, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																								
22b. SIGNATURE <u>Issam F. el Damalouji</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED <u>2-3-69</u>														
22d. PHYSICIAN'S NAME (Type) <u>Issam F. el Damalouji, M.D.</u>										22e. ADDRESS <u>Prince Frederick, Maryland</u>														
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City or Town) (County) (State)									
Burial					2-5-1969					St. Mary's Ch. Cem.					Bryantown, Chas. Co. Md.									
24. FUNERAL DIRECTOR <u>Martell Adams Aguasco, Md.</u> ADDRESS										25a. REC'D BY REGISTRAR <u>FEB 1 1969</u> DATE					25b. REGISTRAR'S SIGNATURE									

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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FOR STATE HEALTH DEPT.

<div>02198</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>02194</div>											
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH		2b. HOUR			
Sarah			AMANDA			Cook		<div>Month Day Year</div> <div>19 69</div>			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE	IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD			
female	white	Sept 2 - 1894	74 YRS	MONTHS DAYS HOURS MIN		February 25, 19 69		<div>Month Day Year</div> <div>10:30 A.M.</div>			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		9. COUNTY OF DEATH					
Raytown - Missouri		U.S.A.		<div>NEVER MARRIED</div> <div>WIDOWED</div> <div>DIVORCED</div>		Calvert		Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Prince Frederick			Calvert County Hospital								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
Maryland			Calvert		North Beach		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		801 5th Street		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
HARRY			BROWN			MAUDE		JOHNSON			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT		ADDRESS			
						Harold S. Beck Jr.		10114 Dallas Ave. S.E.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease											
4124											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF (b)											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
Fracture of Hip											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
CAUSE OF DEATH				3:00 P.M. 2/21 19 69		subj. fell down steps at home					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
				home						Calvert, Md.	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE						CHIEF MEDICAL EXAMINER		ASSISTANT MEDICAL EXAMINER		22b. DATE SIGNED	
Werner U. Spitz, M.D.								<input checked="" type="checkbox"/>		2/25/69	
EXAMINER'S NAME (Type)						DEPUTY MEDICAL EXAMINER		ADDRESS (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial			2-28-1969		Fort Lincoln Cem.			Hagerstown, Md.			
24. FUNERAL DIRECTOR						ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
J. H. ...						254 Carroll St. N.W.		FEB 28 1969		J. H. ...	

8420

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02199

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02195

1. DECEASED-NAME (Type or print) First Middle Last Mary Alice Douglas			2a. DATE OF DEATH Month Day Year 2 27 69		2b. HOUR 555 PM
3. SEX female	4. RACE negro	5. DATE OF BIRTH 3-17-16		6. AGE (In years last birthday) 52 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) Mississippi	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Calvert Md.		
10. CITY OR TOWN OF DEATH Prince Frederick	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Calvert County Hosp.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSE WORK		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Calvert	13c. CITY OR TOWN Sunderland	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER	
14. FATHER'S NAME First Middle Last Robert Davis		15. MOTHER'S MAIDEN NAME First Middle Last Villee Walker			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) no		16b. SOCIAL SECURITY NO. 578-34-2175		17. INFORMANT Address Mable Hawkins Sunderland, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 Coronary Occlusion DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from Feb. 18, 1969 , to Feb. 27 1969 , that (I) (we) last saw the deceased alive on Feb. 27 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Page C. Jett</i>				22c. DATE SIGNED 2-28-69	
22d. PHYSICIAN'S NAME (Type) Page C. Jett, M.D.				22e. ADDRESS Prince Frederick, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 3-2-69		23c. NAME OF CEMETERY OR CREMATORY Patuxent Ch. Cem.	
24. FUNERAL DIRECTOR <i>Anthony E. Sewell</i>		23d. LOCATION (City or Town) (County) (State) Heatingtown Cal. 119		25a. REC'D BY REGISTRAR DATE MAR 4 1969	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

FOR STATE
HEALTH DEPT.

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02200

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02196

1. DECEASED-NAME (Type or Print) <i>Bertha Marie</i> <i>Dowell</i>				2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 26 69 8104				2b. HOUR	
3. SEX <i>F</i>	4. RACE <i>W</i>	5. DATE OF BIRTH <i>2/20/97</i>	6. AGE (In years last birthday) <i>71</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year 19 M	
7a. BIRTHPLACE (State or foreign country) <i>Calvert</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Calvert</i> Md.			
10. CITY OR TOWN OF DEATH <i>Sumner</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not at home street address) <i>Calvert</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Ret.</i>				12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md</i>		13b. COUNTY <i>Calvert</i>		13c. CITY OR TOWN <i>Sumner</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>Rural</i>	
14. FATHER'S NAME First Middle Last <i>Wm</i> <i>Sumner</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Wm</i> <i>Dowell</i> <i>Sumner</i>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			
16b. SOCIAL SECURITY NO.			17. INFORMANT <i>Wm Dowell Sumner</i>			ADDRESS <i>Md</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <i>880X</i> IMMEDIATE CAUSE (a) <i>Broken neck</i> DUE TO, OR AS A CONSEQUENCE OF <i>Fell down stairs</i> (b) <i>Fell down stairs</i> DUE TO, OR AS A CONSEQUENCE OF (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Fell down stairs, hospitalized 8 days</i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <i>26 69</i>			21b. TIME OF INJURY Month, Day, Year HOUR A.M. <i>26 69</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) <i>Fell down stairs</i>			
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Home</i>			21f. LOCATION Street or R.F.D. No. City or Town County State <i>Sumner Calvert Md</i>			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>H. W. Ward</i>			M.D. <i>H. W. WARD</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <i>H. W. WARD</i>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			22b. DATE SIGNED <i>2/6/69</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE <i>Feb 8, 1969</i>			23c. NAME OF CEMETERY OR CREMATORY <i>St. Charles Episcopal</i>			
24. FUNERAL DIRECTOR <i>Hutchins Funeral Home</i>			ADDRESS <i>Ward, Md</i>			25. REC'D BY REGISTRAR DATE <i>FEB 13 1969</i>			
						25b. REGISTRAR'S SIGNATURE <i>Charles Yung</i>			

03186

25 4/10/82

Robert

Wells

Robert Wells

James

Wells & Wells

Robert Wells

Robert Wells

Robert Wells

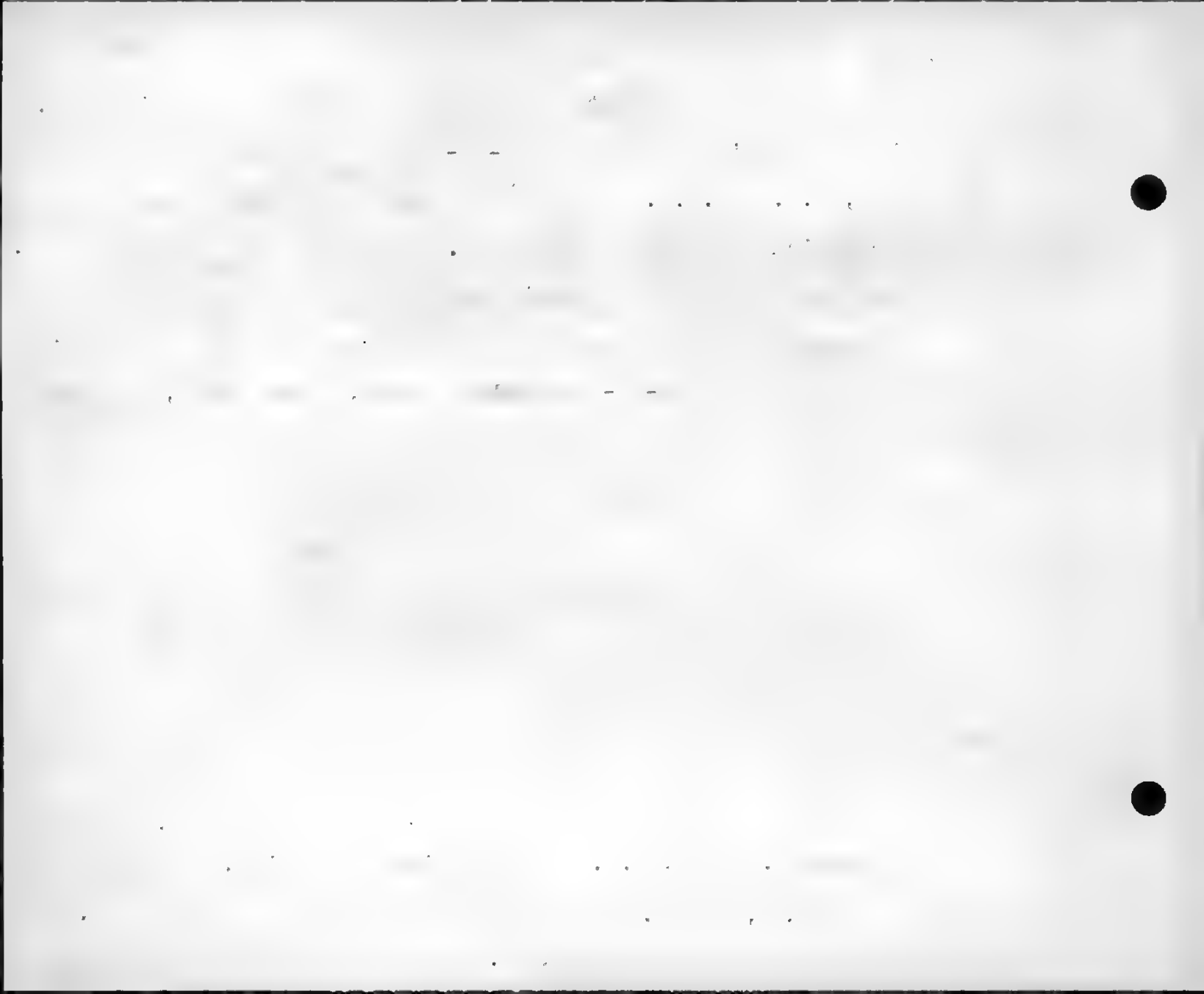
Robert Wells

1982 2 1 677

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

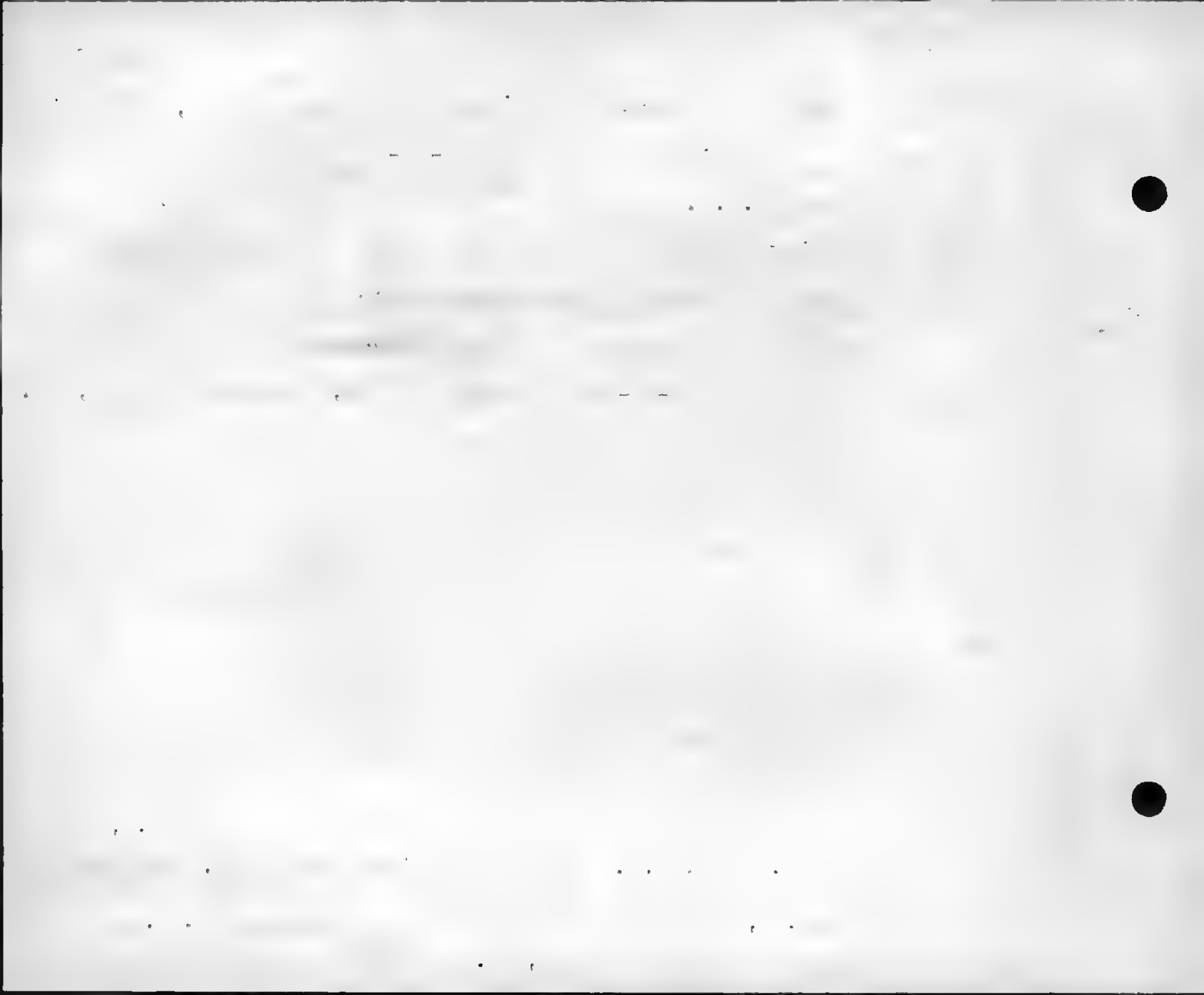
MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) Anne			First Frances			Middle Feaster			Last		
3. SEX Female			4. RACE White			5. DATE OF BIRTH 2-12-99			6. AGE (In years last birthday) 70 YRS.		
7a. BIRTHPLACE (State or foreign) Washington, D.C.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Calvert County Md.		
10. CITY OR TOWN OF DEATH Prince Frederick			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Calvert County Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Operator			12b. KIND OF BUSINESS OR INDUSTRY Telephone Co.		
13a. USUAL RESIDENCE (Where deceased lived, if institut on: Residence before admission) STATE Maryland			13b. COUNTY Calvert			13c. CITY OR TOWN North Beach			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME First John			Middle Kelly			Last			15. MOTHER'S MAIDEN NAME First Mary		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No			16b. SOCIAL SECURITY NO 579-22-8106			17. INFORMANT Lola			Address Lauder, North Beach, Maryland		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Circulatory collapse DUE TO, OR AS A CONSEQUENCE OF Congestive heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. _____ Month _____ Day _____ Year 19 P.M. _____			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. _____			City or Town _____		County _____ State _____
22a. I certify that (I) (this hospital) attended the deceased from February , 19 54 , to Feb 14 , 19 69 , that (I) (we) last saw the deceased alive on Feb 14 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Osman Z. Ersoy, M.D.			DEGREE M.D.			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED Feb. 15, 1969		
22d. PHYSICIAN'S NAME (Type) Osman Z. Ersoy, M.D.			22e. ADDRESS Prince Frederick, Maryland								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE Feb. 17, 1969			23c. NAME OF CEMETERY OR CREMATORY So. Memorial Gardens			23d. LOCATION (City or Town) (County) (State) Dunkirk Calvert Md.		
24. FUNERAL DIRECTOR Stetson Funeral Home			ADDRESS Owings, Md.			25a. RECD BY REGISTRAR DATE 9 19 1969			25b. REGISTRAR'S SIGNATURE		



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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Harold Francis Finlon						February 2, 1969			12 P.M.
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS
Male		White		10-11-05			63 YRS.		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Pennsylvania		U.S.A.				Calvert County Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY
Prince Frederick			Calvert County Hospital			Amusement Park Manager			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER		
Maryland			Calvert		Chesapeake Beach	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Frank Finlon			Teresa Buckley			Teresa Buckley			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
No			577-16-1871		Mildred Finlon, Chesapeake Beach, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Sky Divers Disease									3 1/2 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Arteriosclerosis									5 years
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
		P.M. 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from Dec 2, 1967, to 2/2, 1969, that (I) (we) last saw the deceased alive on 2/1, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE				22c. DATE SIGNED					
Page E. Jett, M.D.				Feb. 2, 1969					
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
Page E. Jett, M.D.				Prince Frederick, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		Feb. 5, 1969		Cedar Hill Cemetery		Washington D. C.			
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Hutchins Funeral Home				Owings, Md.		DATE FEB 6 1969		Hutchins	

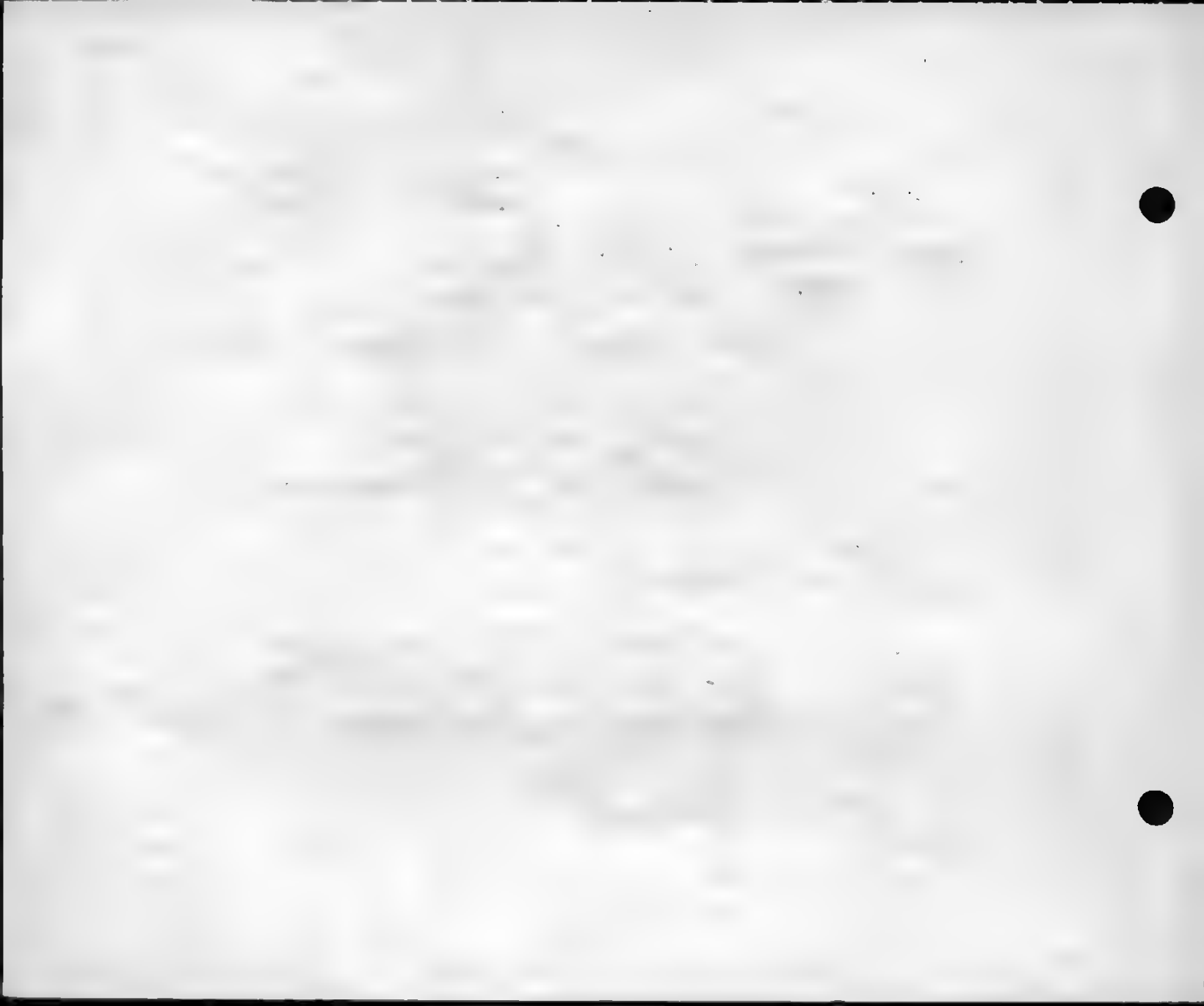


FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
02203									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
02199									
1 DECEASED-NAME (Type or Print) <i>Wanjie H. Harten</i>						2a DATE KNOWN OF DEATH <i>25</i> Month <i>19</i> Year <i>69</i>		2b HOUR <i>450</i>	
3 SEX <i>F</i>		4 RACE <i>W</i>		5 DATE OF BIRTH <i>11/20/60</i>		6 AGE (In years) <i>88</i> YRS		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country) <i>Md</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Calvert</i>		Md.	
10 CITY OR TOWN OF DEATH <i>Prince Frederick</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Calvert Co H</i>				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Retired</i>		12b KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before adm ssion) STATE <i>Md</i>				13b COUNTY <i>Calvert</i>		13c STREET AND NUMBER <i>Solomons</i>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME First <i>Sid</i> Middle <i>W</i> Last <i>Howard</i>				15 MOTHER'S NAME First <i>Margaret</i> Middle <i>Carey</i> Last <i>Carey</i>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <i>No</i>				16b SOCIAL SECURITY NO. <i>217-03-6507</i>		17 INFORMANT ADDRESS			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Internal, injury</i>								<i>12 hrs</i>	
(b) <i>Fell at Home</i>									
(c) <i>Fell at Home</i>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month, Day, Year <i>2/25/69</i> HOUR A.M. <i>PM</i>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>Got walking</i>			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Home</i>		21f LOCATION Street or R.F.D. No. City or Town <i>Solomons</i> County <i>Calvert</i> State <i>Md</i>			
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>H.W. Ward</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b DATE SIGNED <i>2/25/69</i>			
EXAMINER'S NAME (Type) <i>H.W. Ward</i>				M.D. <i>M.D.</i>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				ADDRESS (Street, city, town, or county) <i>Quikings Md.</i>					
23a BURIAL CREMATION, REMITAL (Specify) <i>Burial</i>		23b DATE <i>Feb. 28, 1969</i>		23c NAME OF CEMETERY OR CREMATORY <i>Solomons Methodist</i>		23d LOCATION (City or Town) (County) (State) <i>Solomons, Calvert, Md.</i>			
24 FUNERAL DIRECTOR <i>A.G. Andrews, San, Port Republic, Md.</i>				25a REC'D BY REGISTRAR <i>FEB 28 1969</i>		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

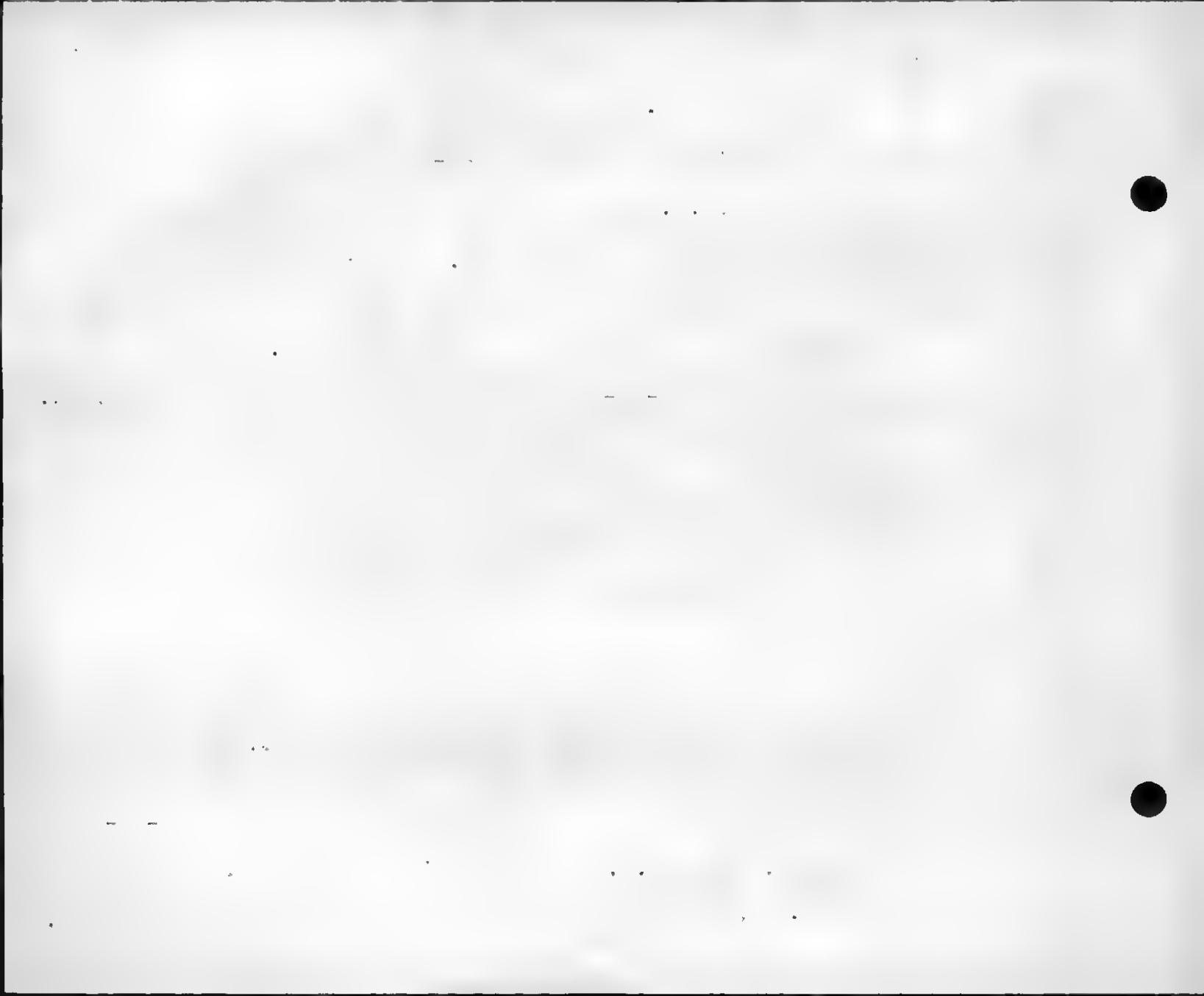


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VR A15 (1)
30M REV

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR				
Mattie			E.			Hatfield			Month 2 Day 26 Year 69 8:57 a				
3 SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		7. UNDER 1 YEAR		7. UNDER 24 HRS.		
female		white		8-8-80			88 YRS.		MONTHS DAYS HOURS MIN		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			9d. ADDRESS	
Maryland			U.S.A.						Calvert			Md.	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY				
Prince Frederick			Calvert County Hosp.			housewife			Domestic				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER	
Maryland			Calvert			Huntingtown						-----	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last										
McHenry			Bowen			Mollie H. Bowen							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)			16b. SOCIAL SECURITY NO			17. INFORMANT			Address				
no			217-36-7193			Morrison Hatfield			Huntingtown, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i>										3 days			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										3 years			
(b) <i>Arteriosclerosis</i>										3 years			
(c) <i>Pulmonary Edema</i>										3 days			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
<i>Cardiomegaly of Pericardium - 2 years</i>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
Burial													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>June 3, 1967</u> to <u>Feb. 26, 1969</u> , that (I) (we) last saw the deceased alive on <u>February 26, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE								DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
<i>Page C. Jett, M.D.</i>										2-26-69			
22d. PHYSICIAN'S NAME (Type)								22e. ADDRESS					
Page C. Jett, M.D.								Prince Frederick, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
Burial			Feb. 28, 1969			Miranda Memorial Cemetery			Huntingtown Calvert Md.				
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
<i>Fun. Home</i>			<i>4 wings, etc</i>			DATE FEB 28 1969			<i>Charles Indale</i>				



FOR STATE
HEALTH DEPT.

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02205

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02201

1 DECEASED-NAME (Type or Print) <i>Richard Russell Howe</i>			2a DATE KNOWN OF DEATH <i>2</i> Month <i>11</i> Day <i>1969</i>			2b HOUR <i>1020A</i>		
3. SEX <i>M</i>	4. RACE <i>C</i>	5. DATE OF BIRTH <i>Feb 27, 1902</i>	6. AGE (In years last birthday) <i>66 YRS</i>	IF UNDER 1 YEAR MONTHS <i></i> DAYS <i></i>	IF UNDER 24 HRS HOURS <i></i> MIN. <i></i>	2c. DATE PRONOUNCED DEAD Month <i>2</i> Day <i>11</i> Year <i>1969</i>		
7a. BIRTHPLACE (State or foreign country) <i>Md</i>		7b. CITIZEN OF WHAT COUNTRY? <i></i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Calvert</i>		
10. CITY OR TOWN OF DEATH <i>Annapolis</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i></i>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Farmer</i>		12b. KIND OF BUSINESS OR INDUSTRY <i></i>
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE <i>Md</i>		13b. COUNTY <i>Calvert</i>		13c. CITY OR TOWN <i>Annapolis</i>		13d. DE CITY LIM IS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		13e. STREET AND NUMBER <i></i>
14. FATHER'S NAME First <i>Isaac</i> Middle <i></i> Last <i>Howe</i>			15. MOTHER'S MAIDEN NAME First <i>Borgh</i> Middle <i>Enoch</i> Last <i></i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16b. SOCIAL SECURITY NO <i>219-16-245-C</i>		17. INFORMANT <i>Nellie Russell</i>		ADDRESS <i>Annapolis Md</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio Vascular and Disease</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Yes</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Yes</i> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Had not walked out for several days</i> <i>Had a pain in stomach and died suddenly</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i></i>
19a. DATE OF OPERATION <i>Had a pain in stomach and died suddenly</i>		19b. CONDITION FOR WHICH OPERATED WAS PERFORMED <i></i>		19c. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <i></i>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <i>19</i> P.M. <i></i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i></i>		21f. LOCATION Street or R.F.D. No <i></i> City or Town <i></i> County <i></i> State <i></i>				
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								22b. DATE SIGNED <i>2/11/69</i>
ACTUAL SIGNATURE <i>A.W. Ward</i> EXAMINER'S NAME (Type) <i></i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county) <i></i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i></i>		23b. DATE <i>2-15-69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Youngs Ch. Cem</i>		23d. LOCATION (City or Town) (County) (State) <i>Huntingtown Cal. Md</i>		
24. FUNERAL DIRECTOR <i>Linker E. Small Prince Fred, Md</i>				25a. REC'D BY REGISTRAR <i></i> DATE <i>FEB 17 1969</i>		25b. REGISTRAR'S SIGNATURE <i></i>		

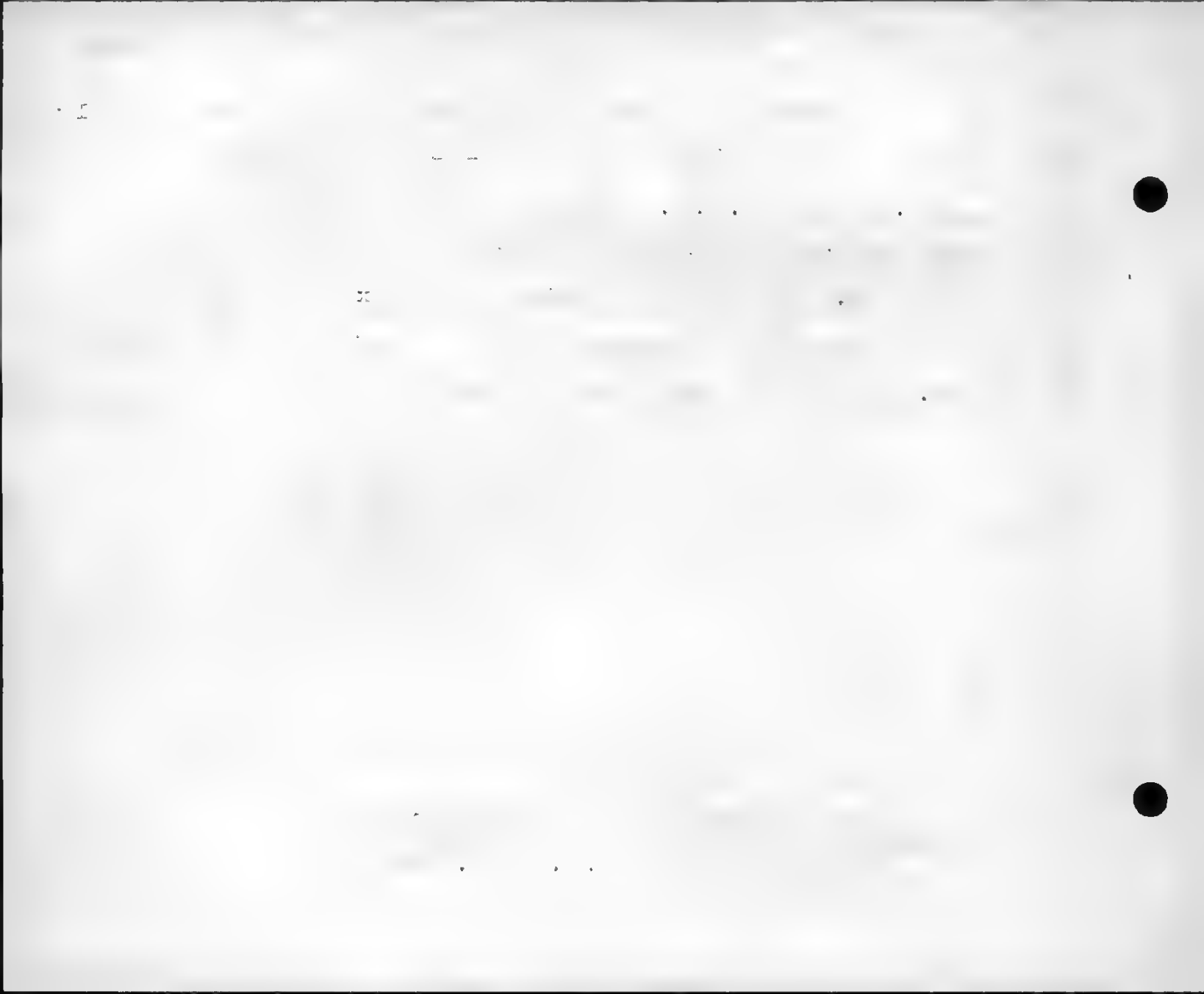


TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VE A15 (4)
30M REV

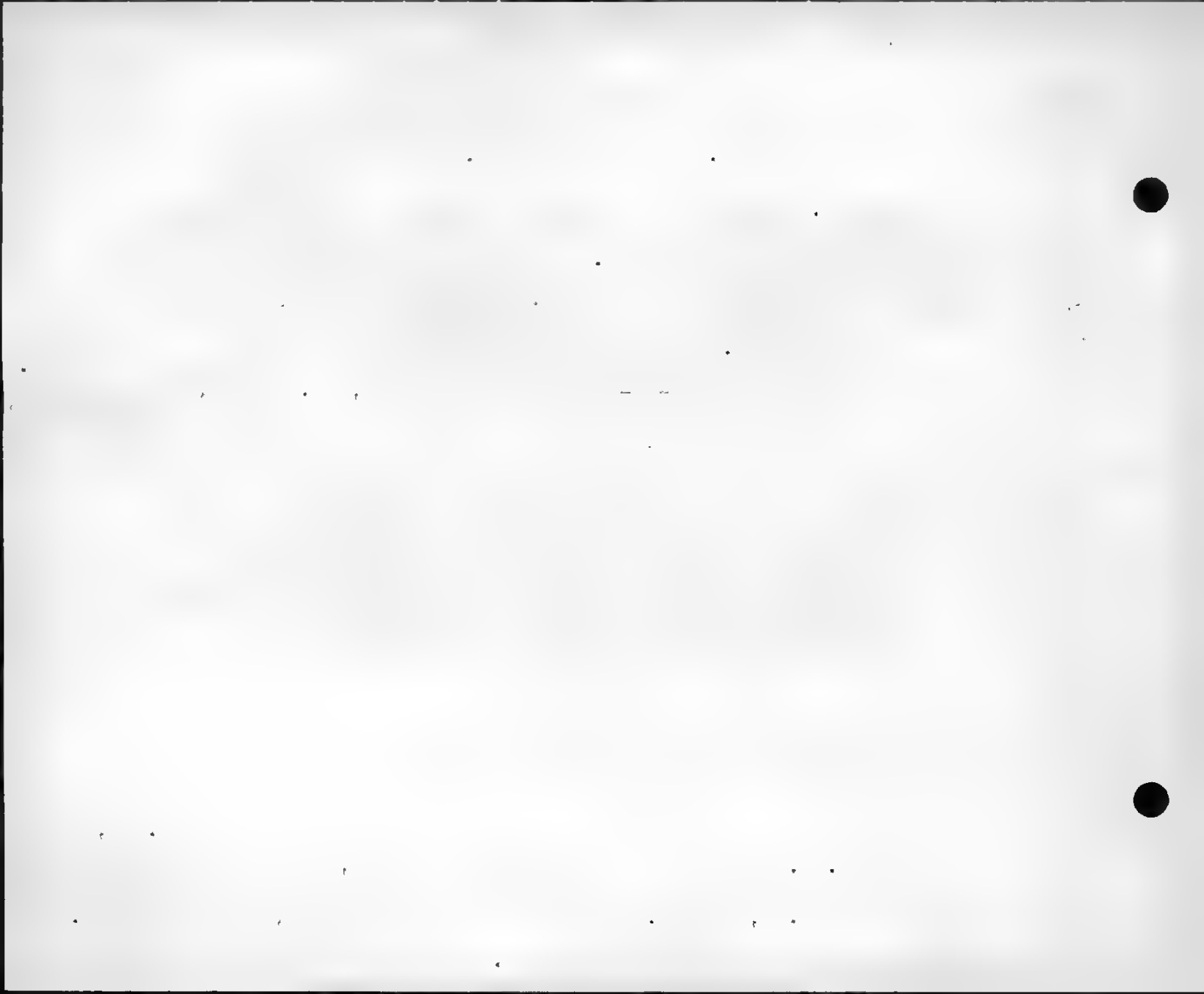
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
CERTIFICATE OF DEATH														
1. DECEASED-NAME (Type or print)			First Joshua			Middle Clyde			Last Humphreys			2a. DATE OF DEATH 2 Month 14 Day 69 Year 12:55 PM		
3. SEX Male			4. RACE White			5. DATE OF BIRTH 11-12-94			6. AGE (In years last birthday) 73 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) Md.			7b. CITIZEN OF WHAT COUNTRY? U. S. A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Calvert			Md.		
10. CITY OR TOWN OF DEATH Prince Frederick			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Calvert County Hospital			12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired) Retired			12b. KIND OF BUSINESS OR INDUSTRY Carpenter					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.			13b. COUNTY Calvert			13c. CITY OR TOWN Lusby			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER		
14. FATHER'S NAME First Joshua			Middle -			Last Humphreys			15. MOTHER'S MAIDEN NAME First Annie			Middle Denton		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No.			16b. SOCIAL SECURITY NO. 216 05 8397			17. INFORMANT Earl Clyde Humphreys			Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cornary occlusion</u>														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pneumonia</u>														
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized Sclerosis</u>														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from <u>2/11/69</u> , 19 <u>69</u> , to <u>2/15/69</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>2-11-1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death														
22b. SIGNATURE <u>Roberto de Villarreal</u>			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>2/10/69</u>								
22d. PHYSICIAN'S NAME (Type) Roberto de Villarreal, M. D.			22e. ADDRESS St. Leonard, Maryland											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE Feb. 16, 1969			23c. NAME OF CEMETERY OR CREMATORY Middleham Chapel Cemetery			23d. LOCATION (City or Town) (County) (State) Lusby Calvert Md.					
24. FUNERAL DIRECTOR <u>G. G. Williams</u>			ADDRESS 5000 Port Republic, Md.			25a. REC'D BY REGISTRAR DATE <u>FEB 17 1969</u>			25b. REGISTRAR'S SIGNATURE <u>William</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it is completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print)			First Middle Last			2c. DATE OF DEATH			2b. HOUR			
AUBREY WILLIAM			Johnson			February 10 1969			11: P M			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Male		Cauc.		Sept. 25, 1909			59 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			
Appahanick, Va.			USA						Calvert Md			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY			
Prince Frederick			Calvert Co. Hospital			Carpenter			Construction			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			
Maryland			Calvert			Ches. Beach			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last									
Charles E. Johnson			Carrie Virginia Johnson									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address			Md.			
No			578-10-6435			Aubrey Johnson, Jr. Box 122, Chesapeake Beach,						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) <u>acute heart failure</u>												
DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												
(b) _____												
DUE TO, OR AS A CONSEQUENCE OF												
(c) _____												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>4/1</u> , 19 <u>66</u> , to <u>2</u> , 19 <u>69</u> , that (I) (we) lost the deceased on <u>2/9</u> , 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE			22c. DATE SIGNED									
<u>G. J. Weems</u>			Feb. 11, 1969									
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS									
G. J. Weems			Huntingtown, Maryland 20639									
23a. BURIAL, CREMATON, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial			Feb. 13, 1969			So. Memorial Gardens			Punkirk, Calvert, Md.			
24. FUNERAL DIRECTOR ADDRESS			25a. REC'D BY REGISTRAR DATE			25b. REGISTRAR'S SIGNATURE						
<u>Hutchins Funeral Home</u>			Owings, Md.			FEB 14 1969						



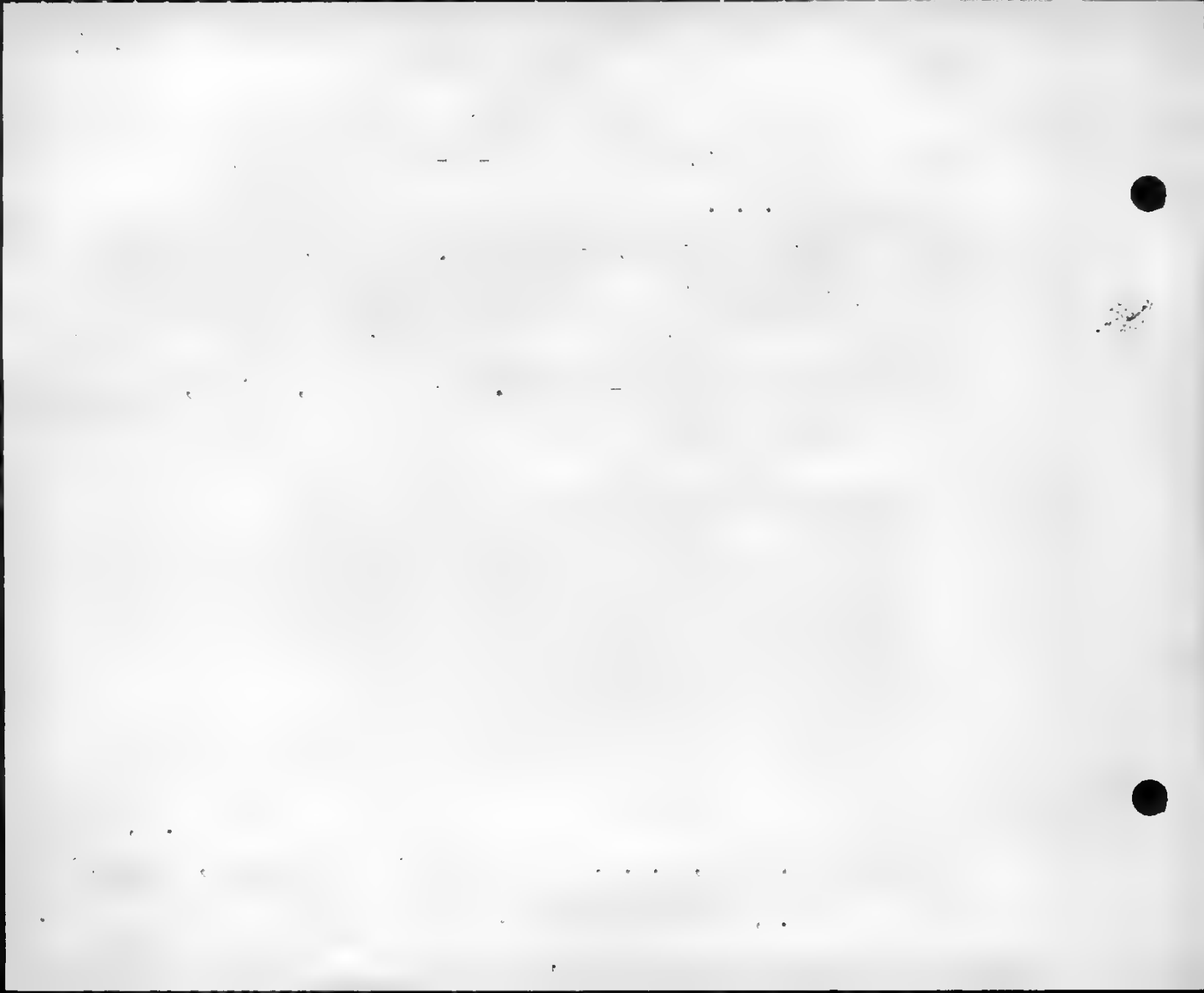
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) Annette Hewitt Jones			2a DATE OF DEATH Month February Day 1 Year 1969		2b HOUR 7:25 M
3 SEX Female	4 RACE White	5 DATE OF BIRTH 10-12-87		6 AGE (In years last birthday) 81 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a BIRTHPLACE (State or foreign country) Maryland	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Calvert County Md.		
10 CITY OR TOWN OF DEATH Prince Frederick	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Calvert County Hosp.		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife	12b KIND OF BUSINESS OR INDUSTRY Domestic	
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b COUNTY Calvert	13c CITY OR TOWN Dunkirk	13d INSIDE CITY LIM TSP YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET AND NUMBER Rural
14 FATHER'S NAME First Charles Middle Last Spiknall		15 MOTHER'S MAIDEN NAME First Maria Middle Last King			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service)		16b SOCIAL SECURITY NO 220-32-6981	17 INFORMANT Address Mrs. Dorothy Ward, Owings, Maryland		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Subarachnoid Hemorrhage 4337 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial Infarct DUE TO, OR AS A CONSEQUENCE OF (c) Left Hemiplegia (Thrombosis)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 hours 48 hours 24 days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19 P.M. 		21c HDW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State 	
22a I certify that (I) (this hospital) attended the deceased from 1/8 , 19 64 , to 2/1 , 19 69 , that (I) (we) last saw the deceased alive on 1/31 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE Page C. Jett				22c. DATE SIGNED Feb. 1, 1969	
22d. PHYSICIAN'S NAME (Type) Page C. Jett, M.D.,				22e. ADDRESS Prince Frederick, Maryland	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Feb. 3, 1969		23c. NAME OF CEMETERY OR CREMATORY Smithville Chr. Cemetery	
23d. LOCATION (City or Town) (County) (State) Dunkirk Calvert Md.					
24 FUNERAL DIRECTOR Hutchins Funeral Home		ADDRESS Owings, Maryland		25a. REC'D BY REGISTRAR FEB 6 1969	
25b. REGISTRAR'S SIGNATURE Charles Judge					

MEDICAL CERTIFICATION



Page 4 may be retained by the hospital or attending physician.

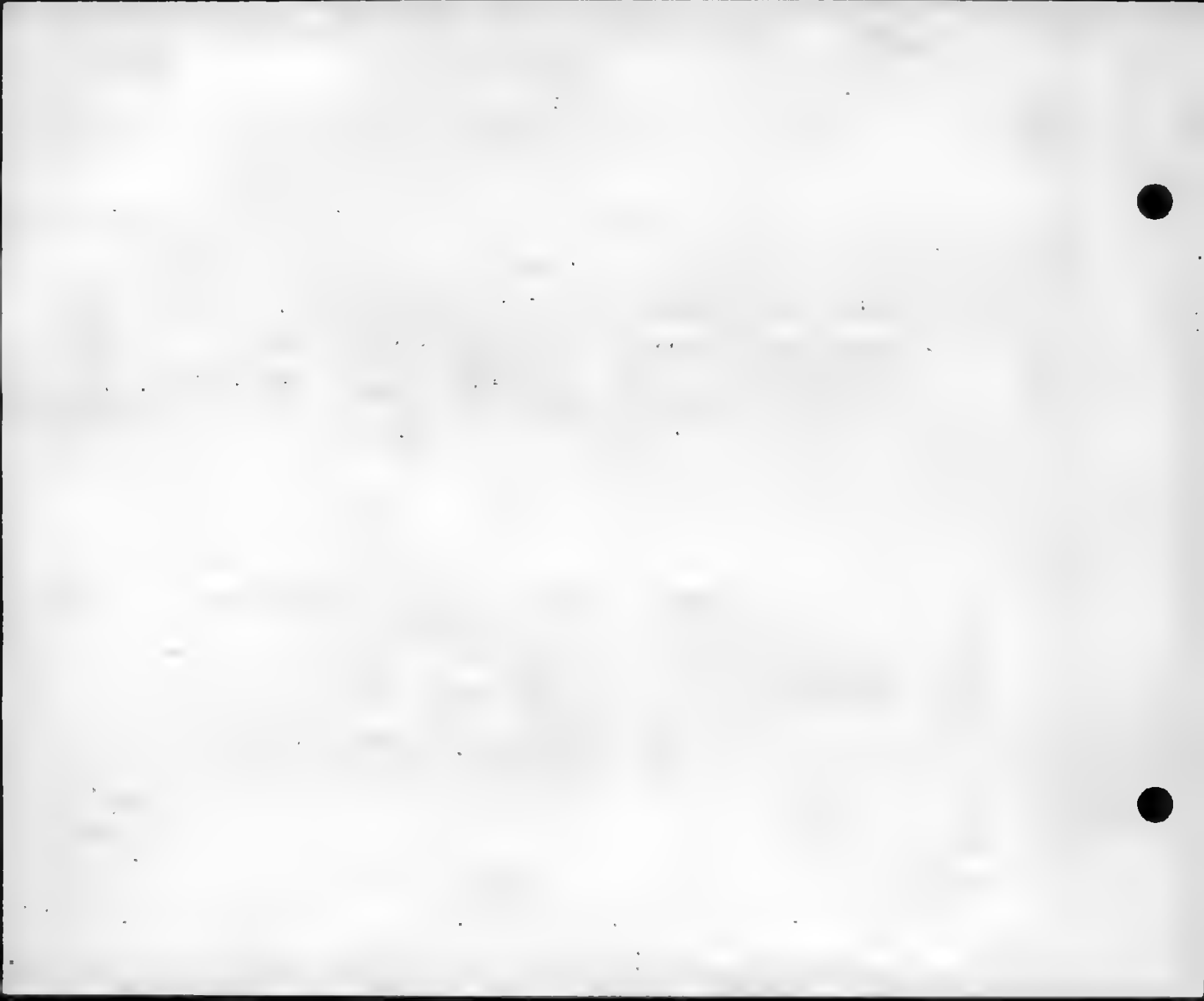
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20

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02205

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR				
Tena VICTORIA				Jones	2 Month 24 Day 69 Year		6 P M				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
F		N		11-21-85		83 8/4 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
M.D.						CALVERT COUNTY		Md			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY					
PRINCE FREDERICK		CALVERT HOUSE INC.		Homemaker							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
A.D.		CALVERT		HUNTING TOWN							
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17. INFORMANT		Address	
C. XXXX Jack Morsell		C. XXXXX Alice Parran						Alice Parran		Prince Fred. Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> 7824 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 2/6, 1969, to 2/24, 1969, that (I) (we) last saw the deceased alive on 2/24, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>[Signature]</u> DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 2/24/69							
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS <u>Abingdon Md</u>		23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 3-1-69		23c. NAME OF CEMETERY OR CREMATORY St. Edmonds Ch. Cem		23d. LOCATION (City or Town) (County) (State) Sunderland Cal. Md	
24. FUNERAL DIRECTOR <u>Lawrence E. Jewell Prince Fred Md</u>		25a. REC'D BY REGISTRAR <u>[Signature]</u> DATE FEB 28 1969		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>							



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

<div>02210</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>02206</div>											
1. DECEASED-NAME (Type or Print) <i>Malcolm Sterling Jones</i>						2a. DATE KNOWN OF ESTI-DEATH MATED <i>2 2 69</i>					
3. SEX <i>M</i>		4. RACE <i>W</i>		5. DATE OF BIRTH <i>11/9/97</i>		6. AGE (In years, months, days) <i>72 YRS</i>		7. IF UNDER 1 YEAR MONTHS DAYS		7. IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <i>Ind</i>			7b. CITIZEN OF WHAT COUNTRY? <i>A.S.A.</i>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. COUNTY OF DEATH <i>Calvert</i>		
10. CITY OR TOWN OF DEATH <i>Solomons</i>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Editor</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution) STATE <i>Ind</i>				13b. COUNTY <i>Calvert</i>				13c. CITY OR TOWN <i>Solomons</i>			
14. FATHER'S NAME First Middle Last <i>Ed Jones</i>				15. MOTHER'S MAIDEN NAME First Middle Last <i>McFarlane</i>				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>			
17. SOCIAL SECURITY NO. <i>577 263 320</i>				18. INFORMANT <i>P. Lore</i>				19. ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardiac failure</i>											
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cere</i>											
DUE TO, OR AS A CONSEQUENCE OF (c) <i>774</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Found dead in home alone</i>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <i>19</i>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>H. W. Ward</i>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <i>H. W. Ward</i>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
						ADDRESS (Street, city, town, or county) <i>Parryville, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE <i>Feb. 6, 1969</i>				23c. NAME OF CEMETERY OR CREMATORY <i>Solomons Methodist Center, Solomons, Calvert, Md.</i>			
24. FUNERAL DIRECTOR <i>A. A. Harless, Jr., Baltimore, Md.</i>				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE <i>William D. Judge</i>			
				DATE <i>FEB 6 1969</i>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

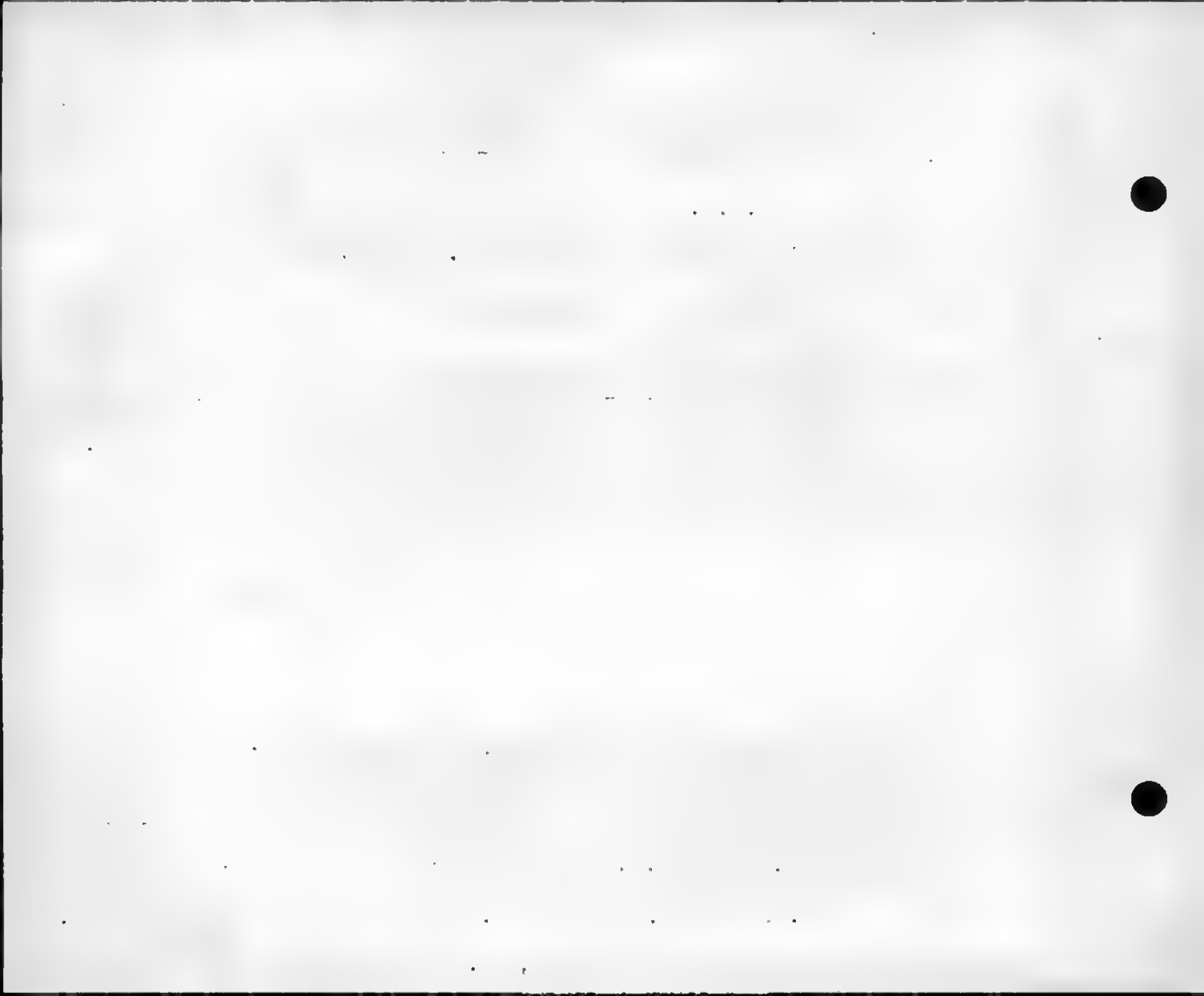
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV.

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR				
Arthur Russell King						Month Day Year 2 27 69			7:10 PM				
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS		
male		white		8-30-98			70 YRS.		MONTHS DAYS		HOURS MIN		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			M.D.	
Maryland			U.S.A.						Calvert				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY				
Prince Frederick			Calvert County Hosp.			merchant							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET AND NUMBER	
Maryland			Calvert			Owings			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			-----	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME										
First Middle Last Cephus King			First Middle Last Ellen King										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address				
---			217-03-5466			Sadie King			Owings, Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))													
PART I. DEATH WAS CAUSED BY.													
IMMEDIATE CAUSE (a) <u>Carcinoma of head of pancreas</u>													
DUE TO, OR AS A CONSEQUENCE OF													
(b) _____													
DUE TO, OR AS A CONSEQUENCE OF													
(c) _____													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
						YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION			City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>Oct. 26</u> , 19 <u>64</u> , to <u>Feb. 27</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>Feb. 27</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE									22c. DATE SIGNED				
<i>Page C. Jett</i>									2-28-69				
22d. PHYSICIAN'S NAME (Type) <u>Page C. Jett, M.D.</u>									22e. ADDRESS <u>Prince Frederick, Maryland</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
Burial			Mar. 2, 1969			Mt. Harmony Chr. Cemetery			Owings Calvert Md.				
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
<i>Suttons Funeral Home</i>						Owings, Md.			DATE <u>MAR 4 1969</u> <i>Charles Judge</i>				

MEDICAL CERTIFICATION

X

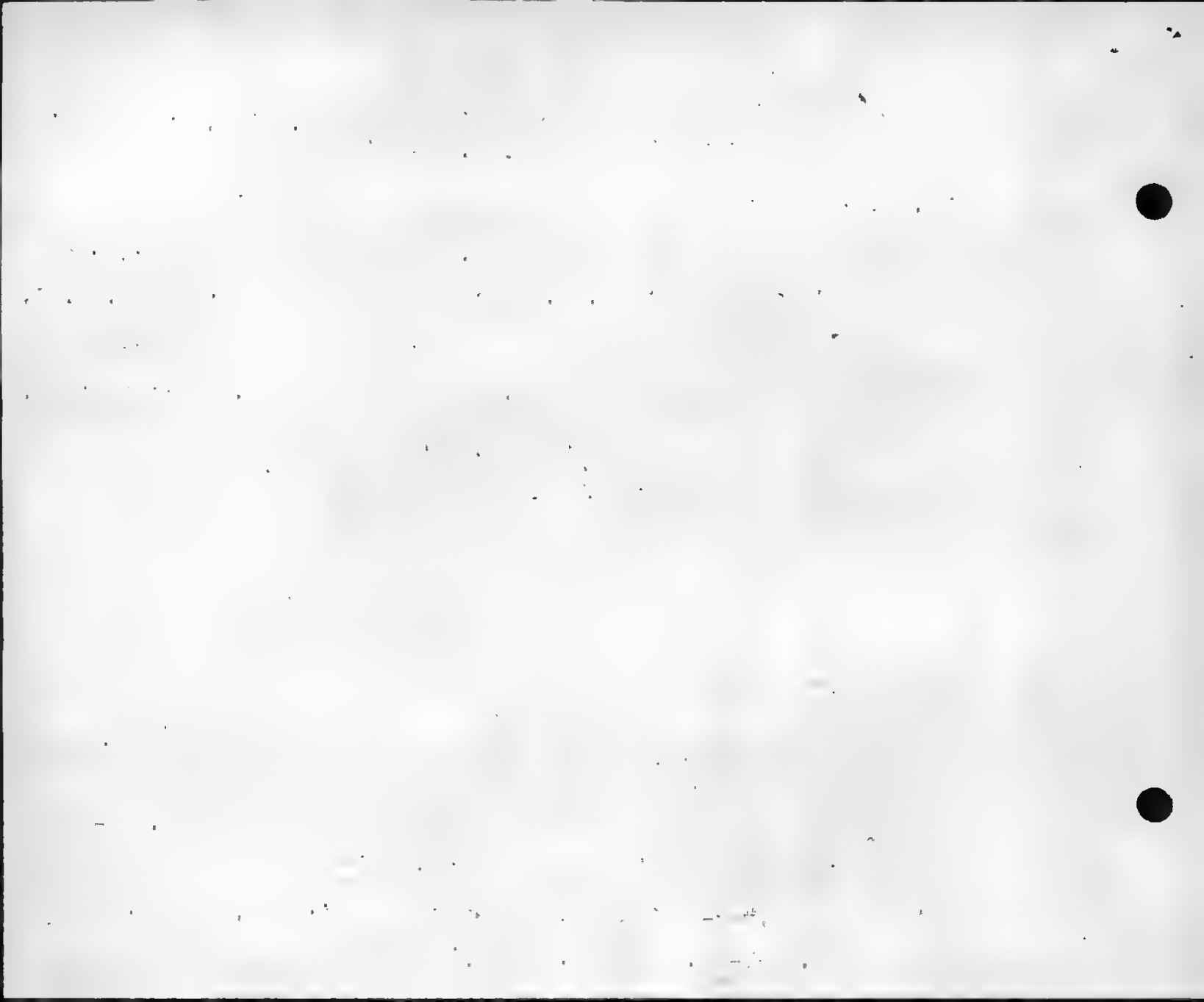


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
30M REV. 1-68

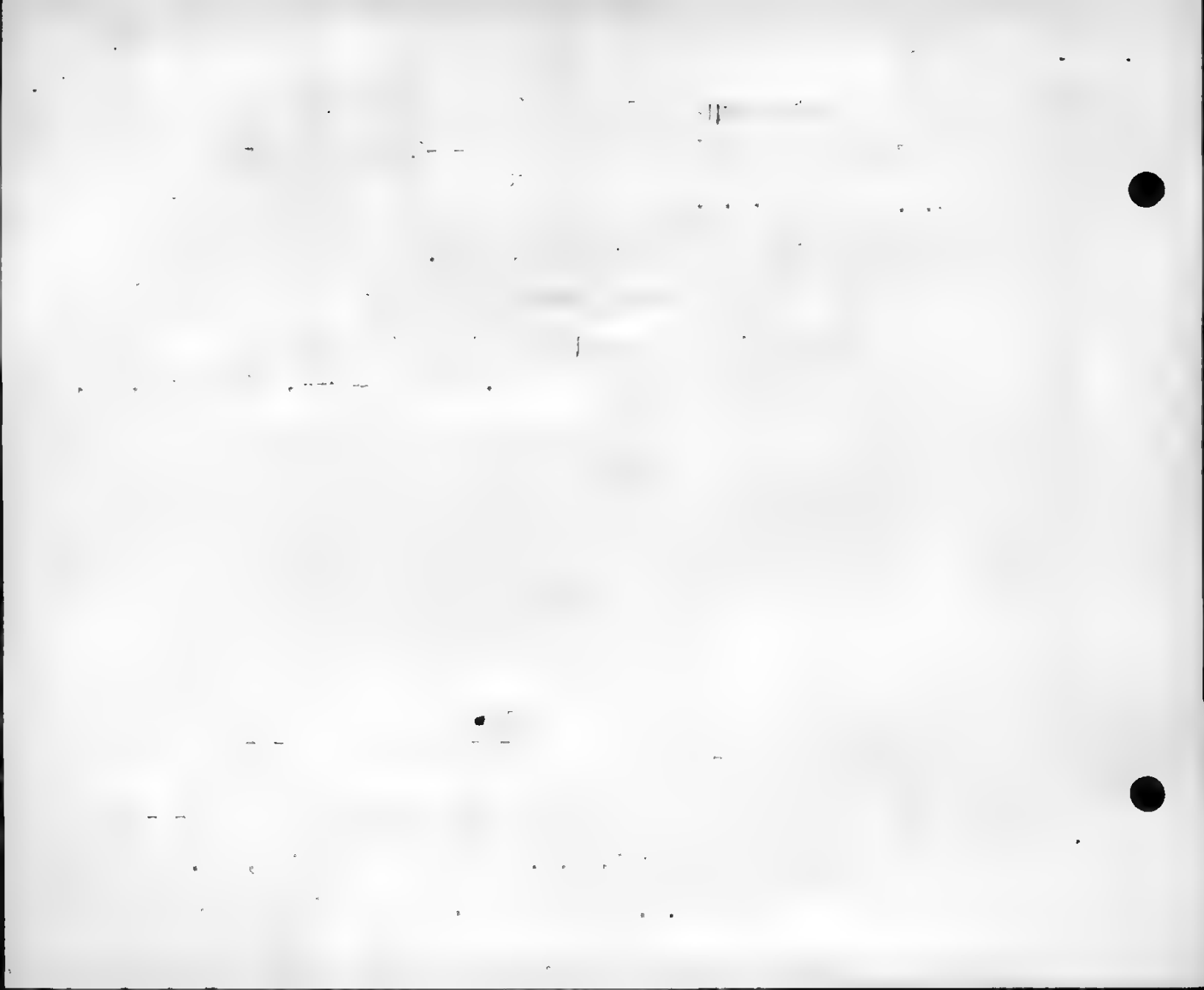
MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) <i>Charles Harry</i> ^{First} <i>KRAMER</i> ^{Middle} ^{Last}						2a. DATE OF DEATH Month <i>Feb.</i> Day <i>28th</i> Year <i>1969</i>			2b. HOUR <i>8.15</i> ^P		
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>Oct. 29-1888</i>		6. AGE (in years last birthday) <i>80</i> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>Balt. Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Calvert County</i> Md					
10. CITY OR TOWN OF DEATH <i>Calvert County</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Calvert House Corp.</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Retired</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Painter</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i> 13b. COUNTY <i>Calvert Co.</i>				13c. CITY OR TOWN <i>N. Beach</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>500- Dayton Ave. N. B.</i>			
14. FATHER'S NAME ^{First} <i>Charles</i> ^{Middle} <i>Henry</i> ^{Last} <i>Kramer</i>				15. MOTHER'S MAIDEN NAME ^{First} <i>Julia</i> ^{Middle} <i>Rangmann</i> ^{Last}							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> (If yes give war or dates of service)				16b. SOCIAL SECURITY NO.		17. INFORMANT <i>M. Ruth Jenkins (Dau.)</i> Address <i>Same as # 13.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> DUE TO, OR AS A CONSEQUENCE OF <i>arteriosclerosis & atherosclerosis</i> (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <i>2/26</i> , 19 <i>69</i> , to <i>2/28</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>2/28</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Osman Ersy</i>				22c. DATE SIGNED <i>Feb. 28-1969</i>		22d. PHYSICIAN'S NAME (Type) <i>Osman Ersy</i>		22e. ADDRESS <i>Prince Frederick, Maryland</i>			
23a. BURIAL, CREMATION, or other disposition (Specify)		23b. DATE <i>March, 3-69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Suitland, Maryland</i>					
24. FUNERAL DIRECTOR <i>Simmons Bros.</i> ADDRESS <i>Wash. DC.</i>				25a. REC'D BY REGISTRAR <i>Wash. DC.</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					



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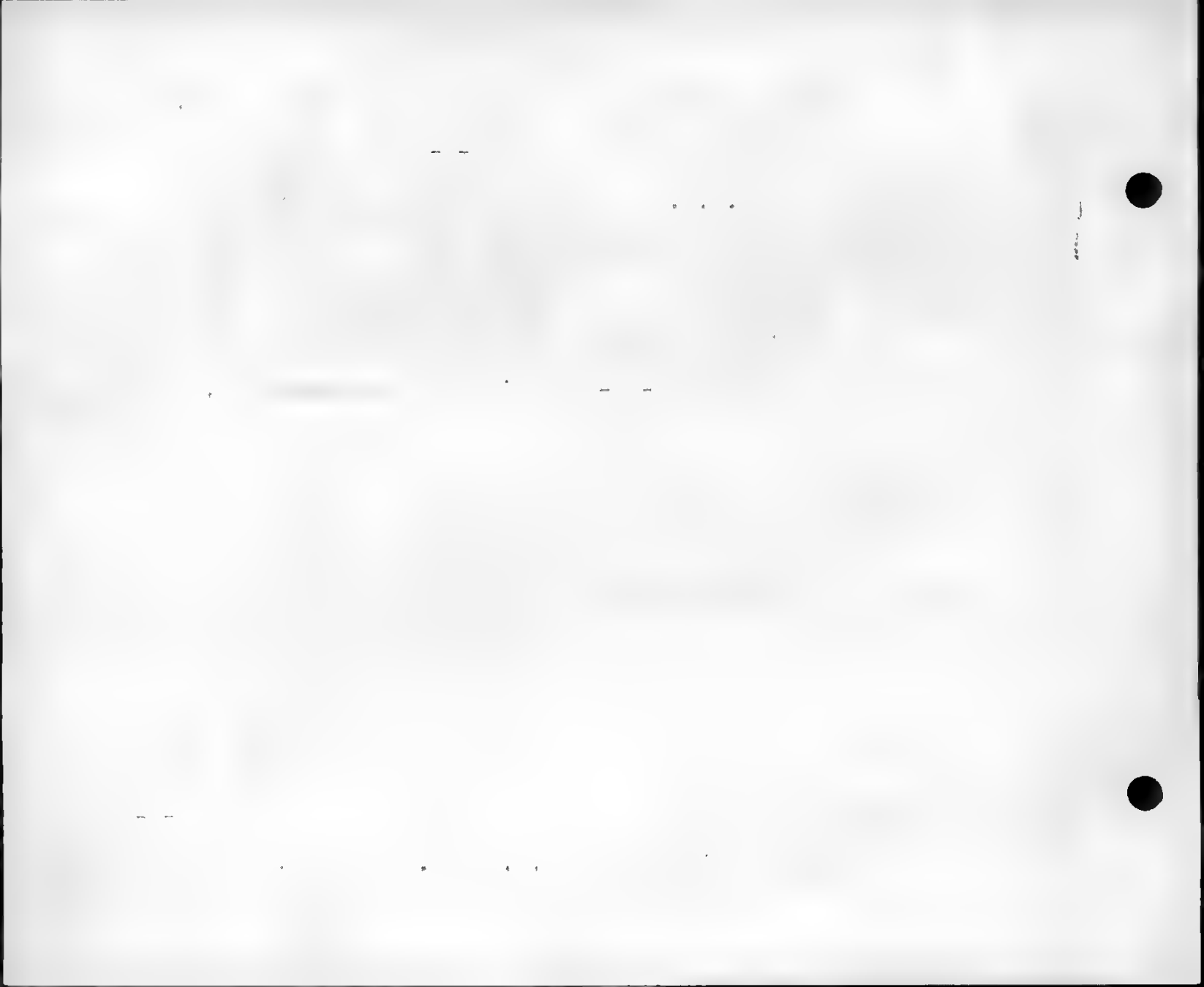
MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			Month Day Year		
Lauterbach, Paul			Harry			February 8			1969 12		
3. SEX			4 RACE			5 DATE OF BIRTH			6 AGE (In years last birthday)		
Male			White			3-9-1911			59 YRS.		
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
D.C.			U.S.A.						Calvert County Md.		
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Prince Frederick			Calvert County Hosp.			REAL ESTATE BROKER					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)			13b. CITY OR TOWN			13c. INSIDE CITY LIM 157			13e STREET AND NUMBER		
Maryland			Anne Arundel			Rosehaven			Lake Shore Drive		
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME								
George Edwin Lauterbach			Alice Belle Lucas								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war and dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address		
Yes			Air Force			Mrs. Margie Lucas, Rosehaven, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)										Nobility coronary	
4107 DUE TO, OR AS A CONSEQUENCE OF										Thromboses.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF (b)											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
			HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>						19					
22a. I certify that (I) (this hospital) attended the deceased from 1965 to 2-8-69, 19, to 2-8-69, 19, that (I) (we) lost the deceased alive on 2-8-69 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE						DEGREE			22c. DATE SIGNED		
Issam El Damalouji, M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			2-9-69		
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
Prince Frederick, Md.											
23a. BURIAL, CREMATION, REMOVA (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
BURIAL			2-12-1969			W.W. Chambers Co.			Riverdale, Maryland		
24 FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
WILL CHAMBERS CO, RIVERDALE MD.						FEB 13 1969					



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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
<div style="display: flex; justify-content: space-between;"> 02214 CERTIFICATE OF DEATH 02210 </div>											
1. DECEASED NAME (Type or print) Mary Elizabeth Makle						2a. DATE OF DEATH February 9, 1969			2b. HOUR 11 A.		
3. SEX Female		4. RACE Negro		5. DATE OF BIRTH 4-3-01		6. AGE (in years last birthday) 67 YRS.		7. UNDER 1 YEAR MONTHS DAYS 		7. UNDER 24 HRS. HOURS MIN. 	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Calvert County Md.					
10. CITY OR TOWN OF DEATH Prince Frederick			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Calvert County Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE Maryland 13b. COUNTY Charles				13c. CITY OR TOWN Waldorf		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
14. FATHER'S NAME First Alowishis Middle Bowman Last 				15. MOTHER'S MAIDEN NAME First Molinda Middle Coots Last Wade							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 213-16-2880		17. INFORMANT Address Lillian Farmer, Waldorf, Maryland							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma 180 X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Melanoma in lymph node DUE TO, OR AS A CONSEQUENCE OF (c) Lymphoma										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. 19 Month Day Year 		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. 115/65 City or Town 2/4 County 59 State 							
22a. I certify that (I) (this hospital) attended the deceased from 1/5/69 , 19 69 , to 2/4 , 19 69 , that (I) (we) lost sub 9 the deceased alive on 2-9-69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Roberto de Villarreal		22c. DATE SIGNED 2-9-69		22d. PHYSICIAN'S NAME (Type) Roberto de Villarreal, M.D.		22e. ADDRESS St. Leonards, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2-12-69		23c. NAME OF CEMETERY OR CREMATORY St. Marys Church Cem.		23d. LOCATION (City or Town) (County) (State) Bryantown, Chas. Co. Md.					
24. FUNERAL DIRECTOR Martell Adams Aguasco, Md.		25a. REC'D BY REGISTRAR FEB 14 1969		25b. REGISTRAR'S SIGNATURE Martell Adams Aguasco							



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
1. DECEASED-NAME (Type or Print) <u>Fred.</u>			First Middle Last			20. DATE KNOWN <input checked="" type="checkbox"/> Month Day Year		2b. HOUR OF DEATH ESTI- MATED <input type="checkbox"/> 2 16 1969 11 30 AM					
3. SEX <u>M.</u>		4. RACE <u>W.</u>		5. DATE OF BIRTH <u>MAY 17 1913</u>		6. AGE (In years last birthday) <u>55</u> YRS.		7c. DATE PRONOUNCED DEAD Month <u>2</u> Day <u>16</u> Year <u>1969</u>					
70. BIRTHPLACE (State or foreign country) <u>Wash D.C.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		8. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Calvert</u>		2d. HOUR <u>12</u> M <u>PM</u>					
10. CITY OR TOWN OF DEATH <u>Prince Fred.</u>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Calvert Co. Hosp.</u>			120. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Retired</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Merchant</u>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>md.</u>			13b. COUNTY <u>Calvert</u>		13c. CITY OR TOWN <u>LUSBY</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>186 Tahoe Trail</u>				
14. FATHER'S NAME <u>Fred.</u>			15. MOTHER'S MAIDEN NAME <u>MARGARET</u>			16. SOCIAL SECURITY NO. <u>577-09-7371</u>		17. INFORMANT <u>Marion H. McLelland (Wife)</u>		ADDRESS <u>above ad-</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16b. SOCIAL SECURITY NO. <u>577-09-7371</u>			17. INFORMANT <u>Marion H. McLelland (Wife)</u>		ADDRESS <u>above ad-</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))													
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4109</u> <u>CORONARY THROMBOSIS</u>													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Acute a massive.</u>													
(c) <u></u>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u></u>													
19a. DATE OF OPERATION <u></u>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <u></u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <u></u>			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <u>19</u>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <u></u>							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <u></u>			21f. LOCATION Street or R.F.D. No. <u></u>			City or Town <u></u>		County <u></u> State <u></u>		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <u>Essen F. McLelland</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			22b. DATE SIGNED <u>2-16-69</u>	
EXAMINER'S NAME (Type) <u></u>			ADDRESS (Street, city, town, or county) <u></u>										
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE <u>2/19/69</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cem.</u>			23d. LOCATION (City or Town) <u>Colmar Manor, Md</u> (County) <u></u> (State) <u></u>				
24. FUNERAL DIRECTOR <u>Nalley's Funeral Home Inc.</u>			ADDRESS <u>1111 N. Rainier, Maryland</u>			25a. REC'D BY REGISTRAR <u>FEB 21 1969</u>			25b. REGISTRAR'S SIGNATURE <u></u>				

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02216

CERTIFICATE OF DEATH

02212

1. DECEASED-NAME (Type or print) <i>Almas Davidson Neeld</i>			2a. DATE OF DEATH Month <i>Feb.</i> Day <i>2</i> Year <i>1969</i>			2b. HOUR <i>9:30 PM</i>	
3. SEX <i>male</i>		4. RACE <i>white</i>		5. DATE OF BIRTH <i>Aug. 2, 1887</i>		6. AGE (In years last birthday) <i>81</i> YRS.	
7a. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Calvert</i> Md.	
10. CITY OR TOWN OF DEATH <i>Phon Point Huntingtown</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) —		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Retired</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Civil Engineer</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Calvert</i>		13c. CITY OR TOWN <i>Phon Point</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME First <i>Almas Davidson</i> Middle <i>Neeld</i> Last <i>Jr.</i>		15. MOTHER'S MAIDEN NAME First <i>Emma</i> Middle <i>English</i> Last <i>English</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i> (If yes give war or dates of service) —		16b. SOCIAL SECURITY NO. <i>213-22-1865</i>	
17. INFORMANT <i>Robert D. Neeld</i>		Address <i>Phon Point Huntingtown, Md.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hypertensive cardiovascular disease</i> <i>4122</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <i>Carcinoma of prostate</i> DUE TO, OR AS A CONSEQUENCE OF (d) <i>Carcinoma of prostate</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>since 1968</i> <i>July 30, 1969</i> <i>? 1987</i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>July</i> , 19 <i>67</i> , to <i>Feb. 2</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>Jan. 3</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Page C. Jett</i>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>2-3-69</i>	
22d. PHYSICIAN'S NAME (Type) <i>Page C. Jett, M. D.</i>				22e. ADDRESS <i>Prince Frederick, Maryland 20678</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>Feb 5, 1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Emmanuel Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Huntingtown, Calvert, Md.</i>	
24. FUNERAL DIRECTOR <i>A. G. Harbison & Son, Port Republic, Md.</i>				25a. REC'D BY REGISTRAR <i>Williamas Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Williamas Judge</i>	
				DATE <i>FEB 6 1969</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Please verify date
Line "a" Item 18 ?